STATE OF WASHINGTON EMPLOYMENT SECURITY DEPARTMENT
SHARED WORK COMPENSATION PLAN APPLICATION

1. Company	2. Employment Security Reference Number:
Name: _____	_____
Mailing Address: _____	Phone number: _____
City: _____State _____ Zip _____	Fax Number: _____
Physical Location: (if different from mailing): _____	Email: _____
City State Zip	

3. Who will be the Contact person responsible to Liaison with the Shared Work Unit?
   Name/Address: _____Title:_____

   Phone: _____ email: _____Fax:_____

4. Have You Ever had a previous Shared Work Plan? Yes_____ No_____
5. When do you anticipate reducing hours?:_____
6. Please identify a) the affected departments, units, sections, shift(s):_____
   b) the number of employees in each affected department, unit, sections, and/or shift(s):_____
7. **EMPLOYER CERTIFICATION:**

   I certify to the following:

   A. The plan identifies the department(s) to which it applies, and all of the affected employees are full-time (40 hrs a week) workers;
   B. The total reduction in work hours is in lieu of temporary layoffs which would have affected at least ten percent of the employees in the departments, sections, units, shift(s), identified in the plan application;
   C. Health benefits will be not be reduced due to a reduction in hours. Other fringe benefits will continue as before the reduction in hours;
   D. Any corporate officer for whom participation in the Shared Work Program is being requested, must verify full-time employment; and, must have elected voluntary coverage;
   E. All reports and information necessary for the proper administration of the plan will be furnished to the Shared Work Unit.
   F. Modification statement: Authorization to modify the Shared Work Plan, allows the administrative unit to adjust the hours of work, or any other condition, as long as the changes meet the requirements of the original plan approval. Yes_____ No _____

8. _____

Employer Signature Title Date Submitted

9. **NOTE: To be completed by the collective bargaining agent, if applicable.**

Name: Signature: Union: Local:

Return this application to:

Employment Security Department
Shared Work Program Unit
212 Maple Park, 4th Floor
PO Box 9046
Olympia WA, 98507-9046

Phone No. 1-800-752-2500
FAX No. (360) 902-9260
email: SharedWork@ESD.wa.gov

EMSX SWComp (rev 10/01)